Health History Form

Name: _____DOB:_____Account#:_____Date:_____

Please briefly describe what brought you to the doctor today. How long has this been going on? Is there anything that makes it better or worse?

_____

_____

_____

Please put a check mark in the box below if you or anyone in your family has had any of the following medical problems.

Family History	Myself	Diagnosis
☐	☐	Abnormal pap smear
☐	☐	Anemia
☐	☐	Anxiety disorder
☐	☐	Asthma
☐	☐	Arterial fibrillation
☐	☐	Bi-polar disorder
☐	☐	Blood transfusion
☐	☐	Breast cancer
☐	☐	Cervical cancer
☐	☐	Chronic obstructive pulmonary disease
☐	☐	Crohn's disease
☐	☐	Colon cancer
☐	☐	Stroke
☐	☐	Dementia
☐	☐	Depression
☐	☐	Gestational diabetes
☐	☐	Diabetes, type I
☐	☐	Diabetes, type II
☐	☐	Diverticulosis
☐	☐	Deep vein thrombosis (blood clots)
☐	☐	High cholesterol
☐	☐	Fibrocystic breast disease
☐	☐	Gastro esophageal reflux disease (GERD)
☐	☐	Gout
☐	☐	Gastrointestinal bleed
☐	☐	Atherosclerotic coronary artery disease
☐	☐	Congestive heart failure
☐	☐	Valvular heart disease
☐	☐	Substance abuse
☐	☐	Thyroid disorder
☐	☐	Testicular cancer
☐	☐	Tuberculosis
☐	☐	Recurrent urinary tract infection
☐	☐	Varicose veins/phlebitis

Family History	Myself	Diagnosis
☐	☐	Hepatitis A
☐	☐	Hepatitis B
☐	☐	Hepatitis C
☐	☐	Hypertension (high blood pressure)
☐	☐	Myocardial Infarction (heart attack)
☐	☐	Osteoarthritis
☐	☐	Osteoporosis
☐	☐	Prostate cancer
☐	☐	Enlarged prostate
☐	☐	Peptic ulcer disease
☐	☐	Peripheral vascular disease
☐	☐	Renal failure
☐	☐	Renal insufficiency
☐	☐	Rheumatoid arthritis
☐	☐	Seizure disorder
☐	☐	Skin Cancer

Please explain any items that you checked above:

_____

_____

_____

Please list any other medical problems that you or your family members have had:

_____

_____

Please list any surgeries that you have had: Date:

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Please put a check mark in the box below if you have recently been experiencing any of the following symptoms

General:
- ☐ Decreased appetite
- ☐ Dizziness
- ☐ Fatigue
- ☐ Fever
- ☐ Weakness
- ☐ Unintentional weight loss

Eyes:
- ☐ Eye discharge
- ☐ Halos
- ☐ Eye irritation
- ☐ Recent Visual changes

Ears, Nose and Throat
- ☐ Allergy/sinus problems
- ☐ Difficulty swallowing
- ☐ Disruptive snoring
- ☐ Earache
- ☐ Hearing loss
- ☐ Nasal congestion
- ☐ Postnasal drip
- ☐ Runny nose
- ☐ Sneezing
- ☐ Voice change

Cardiovascular:
- ☐ Chest pain
- ☐ Leg cramps with exertion
- ☐ Palpitations/irregular heart beats
- ☐ Swelling of the hands or feet
- ☐ Passing out

Respiratory:
- ☐ Chest congestion
- ☐ Cough
- ☐ Coughing up blood
- ☐ Shortness of breath
- ☐ Sleep disturbance due to breathing
- ☐ Wheezing

Gastrointestinal:
- ☐ Abdominal bloating
- ☐ Abdominal pain
- ☐ Change in bowel habits
- ☐ Difficulty swallowing
- ☐ Constipation
- ☐ Diarrhea
- ☐ Acid reflux/indigestion
- ☐ Black, tarry stool
- ☐ Nausea
- ☐ Rectal bleeding
- ☐ Vomiting

Genitourinary:

Female
- ☐ Decreased libido
- ☐ Breast pain
- ☐ Pain with urination
- ☐ Pain with intercourse
- ☐ Blood in the urine
- ☐ Urinary incontinence
- ☐ Nipple discharge
- ☐ Pelvic pain
- ☐ Urinary frequency
- ☐ Urinary urgency
- ☐ Vaginal discharge
- ☐ Vaginal dryness

Male
- ☐ Decreased libido
- ☐ Decreased urinary flow
- ☐ Discharge
- ☐ Pain with urination
- ☐ Erectile dysfunction
- ☐ Blood in the urine
- ☐ Incontinence
- ☐ Urinating at night
- ☐ Urinary frequency
- ☐ Urinary hesitancy

Musculoskeletal:
- ☐ Back pain
- ☐ Joint pain
- ☐ Joint swelling
- ☐ Muscle aches
- ☐ Muscle cramps

Dermatologic:
- ☐ Acne
- ☐ Hair loss
- ☐ Nail problems
- ☐ Itching
- ☐ Rash
- ☐ Changing moles

Neurological:
- ☐ Difficulty walking
- ☐ Double vision
- ☐ Frequent Falling
- ☐ Headaches
- ☐ Muscle weakness
- ☐ Numbness
- ☐ Seizures
- ☐ Sudden loss of vision
- ☐ Tremors

Psychiatric:
- ☐ Anxiety
- ☐ Depression
- ☐ Insomnia

Endocrine:
- ☐ Excessive thirst
- ☐ Excessive urination
- ☐ Intolerance to cold
- ☐ Intolerance to heat

Hematological:
- ☐ Easy bruising
- ☐ Abnormal Bleeding
- ☐ Enlarged lymph nodes

Allergy:
- ☐ Itchy eyes
- ☐ Hives
- ☐ Seasonal allergies

Social History:

Do you exercise regularly? Yes ☐ No ☐
What type of exercise? _____
How often? _____

Are you:
- ☐ married
- ☐ single
- ☐ divorced
- ☐ living with partner
- ☐ other

How many children do you have?
_____

What is your occupation?
_____

How many years of education do you have?
_____

How did you find out about us?
_____

If you were referred by a friend or family member who was it?
_____

Name: _____DOB:_____Account#:_____Date:_____

When was your last complete physical exam or well woman exam? _____

Cholesterol:
When was your latest cholesterol screen? _____
Normal □ High □
What was the approximate number? _____

Mammogram (females only):
What was the date of your last mammogram? _____
Normal □ Abnormal □

Cervical Cancer (females only):
What was the date of your last pap smear? _____
Normal □ Abnormal □
Have you ever had sex? Yes □ No □
Have you had a hysterectomy? Yes □ No □
Have you ever been diagnosed with cervical, uterine or ovarian cancer? Yes □ No □ which one? _____

Colon Cancer Screening:
Have you had a colonoscopy? Yes □ No □
What was the approximate date? _____
Normal □ Abnormal □
Have you done stool hemoccult cards (test for blood in the stool)? Yes □ No □
What was the approximate date? _____
Normal □ Abnormal □

Osteoporosis:
What was the date of your last bone mineral density? _____
Normal □ Osteopenia □ Osteoporosis □

Substances:
Do you use tobacco? Yes □ No □
What kind? (e.g. cigarettes or chewing tobacco) _____
How much and for how long? _____
If you quit, approximately when did you quit? _____

Do you drink alcohol? Yes □ No □
What kind (beer, wine, hard liquor)? _____
How many per day? _____

Do you use recreational drugs? Yes □ No □
What kind? _____

Immunizations:
When was your last tetanus shot? _____
When was your last flu shot? _____
When was your last pneumonia shot? _____

Prostate Cancer (males only):
What was the date of your last prostate exam? _____
What was the date of your last PSA? _____

Medications:
Do you take more than three medications? Yes □ No □
Do you carry a list of your medications? Yes □ No □
If you have a list, please be prepared to show it to your nurse or medical assistant.
If you don't have a list, please list the medications that you take below.

Drug Name	Strength	How often do you take it?
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

List any medications you are allergic to:

_____